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Clinicians as service designers? Reflections on current transformation in the UK health services

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Summary

The British National Health Service (NHS) has been involved in profound transformation to keep pace with, and shape, changes in our society. Innovation has been driven by the necessity to transform old hierarchical and paternalistic models into a modern health system, moving care closer to home, mobilizing and tailoring services to individual patients' and their carers' needs through the introduction of radically new services. This paper explores a particular element of ongoing NHS reform: Practice Based Commissioning (PBC). Based on first findings of a research project called "Design in Practice. Change and Flexibility within Health Providers" funded by the EPSRC research centre HACIRIC, the authors argue that PBC formally recognizes important forms of grassroots service design, but also introduces additional challenges. The project is based on case studies within the North West Strategic Health Area (UK), and the study of PBC frameworks and everyday PBC practices in this specific context is explored and contrasted with concurrent efforts to bring service design into the public sector, which are focusing on co-design and experience-based design methodologies. It is suggested that these have the potential to help NHS providers address NHS policy demands to use patient feedback in transforming services (DH, 2009), and the authors reflect on possibilities for potentiation through the application of Service Design methods in this context.

Introduction

This paper introduces first results from an 18 months research project called "Design in Practice. Change and Flexibility in Health Providers". The project, funded by the EPSRC

research centre HACIRIC[1], aims to investigate a new framework for commissioning services in the British National Health Service (NHS), called Practice Based Commissioning (PBC). This new model formalizes and seeks to strengthen grassroots innovation practices and gives frontline clinicians a mandate for innovation and transformation of primary and secondary care services. A team of researchers from Lancaster University, Salford University and practitioners from the North West Strategic Health Area (NW SHA) is investigating how this new approach is being implemented, while exploring if and how creative and design methods and skills could support PBC activities.

In the first section we will summarise the main aspects of NHS reform related to our research, while in the second section we will report on how clinicians are currently working within the PBC framework in NW SHA. We will then provide more general reflections on the potential role of Service Design within PBC and anticipate our next research activities.

A Brief Introduction to the NHS

The National Health Service is a publicly funded, nationalised, healthcare system that provides medical care free at the point of access, within the UK. The NHS was introduced in 1948 as a means of providing equitable access to healthcare regardless of income or geography. This social healthcare system is widely utilised and supported in the UK and less than 8% of the population choose an alternative private healthcare provider. The structure of the NHS has, from the beginning, consisted of three strands: social care, provided mainly by local authorities; primary care with General Practitioners (or doctors) as the first point of contact; and secondary care (including acute and elective care) provided in hospitals. The NHS as a whole employs around 1.5 million people and is one of the largest employers in the world. As with most large public service organizations, the NHS is continuously changing under the pressures of providing better services to more and more people for less and less money. The aims of current innovation initiatives in the NHS are thus to either find and benefit from existing efficiencies, or to introduce new practices and procedures that promise to improve the ways in which healthcare is being delivered as cost-effectively as possible.

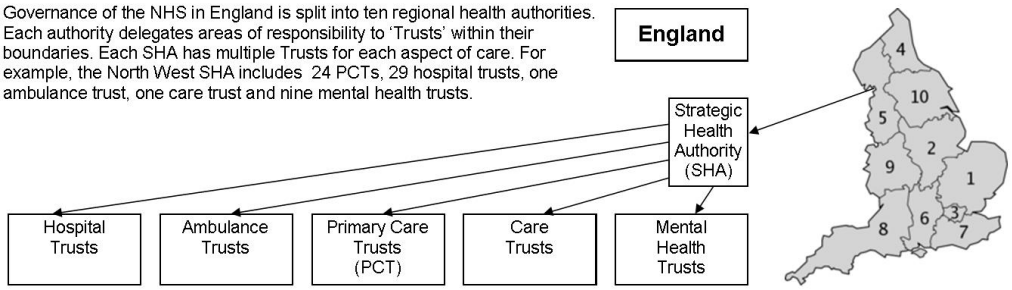

Figure 1. The structure of NHS in England.

[1] The Health and Care Infrastructure Research and Innovation Centre is a collaboration between existing research centres at Imperial College London and the Universities of Loughborough, Reading and Salford. HaCIRIC's focus is on the built and technical infrastructure for health and social care, and the interaction between this infrastructure and change and innovation in care services.

In 2000 the UK government set out an agenda to modernise the NHS through a 10-year plan with a focus on a health service 'designed around the patient' (The NHS Plan 2000). The vision produced for the 21st century NHS is to be, 'an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart' (DoH 2008a). With this in mind, the NHS also revisited the role of clinicians, who typically come most directly and most frequently in contact with patients. PBC is designed to give local clinicians opportunity to combine resources, through the formation of PBC consortia, enabling them to respond better to local needs, and commission new, context- specific services (DH, 2008). From a Service Design perspective, this is a noteworthy development, because PBC can be perceived as 'turning' clinicians 'into' service designers, in as much as it recognizes and supports previously unseen and taken for granted activities, while also formalizing the requirement for these.

NHS and Service Design

The NHS has long understood that it is in the business of designing services. However, only recently has it turned to design methods and practices from the field of design. With the foundation of the NHS Institute for Innovation and Improvement (NHSi) in 2005, the NHS began to explore design and design research as a resource for providing methods for service innovation. Recently, experience design methods have been tailored to the needs of the NHS in form of Experience-Based Design (EBD), developed in collaboration with the Public Service Design agency Think Public (Bate and Robert, 2007). Compared with traditional quantitative methods such as process mapping or surveys, EBD promotes understanding 'experiences' and shows that such understanding is essential to service redesign. In service design EBD is often further facilitated through close involvement of users in participatory or co-design of services. With a similar terminology the Department of Health is now calling for 'real involvement' (DH, 2008) of users and third parties at a range of levels. Such calls for experience-based design, participation and co-design bring great opportunities, but also significant challenges, for clinicians now much more formally charged with devising alternative healthcare service models through PBC.

Practice Based Commissioning

The framework for PBC was established in 2003, with the intention that the majority of GP practices would have mechanisms in place by 2006, and run the scheme by 2008. PBC has been set up by the Department of Health as the framework within which GPs will be expected to reflect on current provision of healthcare in their localities and redesign it where necessary, through engagement with their patients, and through application of their extensive knowledge and experience of patient needs. Significant service innovations are anticipated and encouraged as GPs consider how the current healthcare landscape might be improved, produce proposals and take responsibility for implementing their plans. Department of Health guidance published in 2005 suggests that, 'the freedoms and flexibility of practice based commissioning give front line professionals and managers the information, levers and incentives to improve services in response to the needs of their patients and local populations. It will facilitate clinical engagement, improve access and extend choice for patients and help restore and maintain financial balance.' GP practices are encouraged to

group together to form consortia, increasing purchasing power and influence, and reducing duplication of management structures.

The remit of PBC is to challenge entrenched approaches to the provision of healthcare services, and reshape the boundaries between primary and secondary care, providing the opportunity for a critical examination of patient pathways of care, with an emphasis on bringing care closer to home. The guidance produced for implementation of PBC at both PCT and GP level is deliberately 'light touch' to allow commissioning plans to respond to specific local health problems and needs.

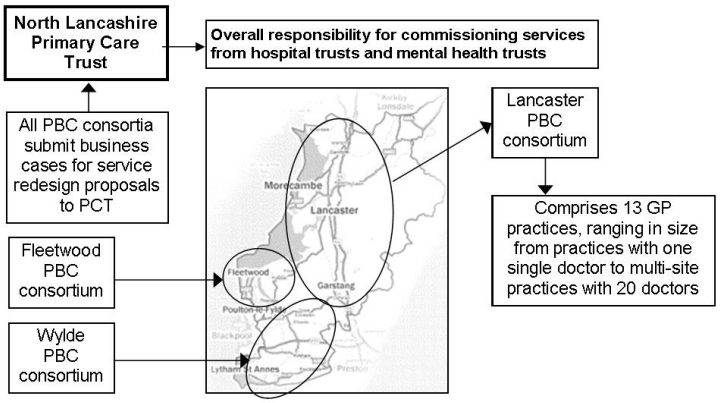

Figure 2: The place of PBC within the PCT

Discovering synergies in case studies

To obtain an in-depth understanding of PBC as it is being applied, and identify points of connection and synergy with service design, we are conducting three case studies in the North West Strategic Health Area (NW SHA). Challenges facing the NW SHA include addressing chronic health problems in the area which has the highest rates in England for deaths from heart disease and stroke, long-term mental health problems, and alcohol related hospital stays. Almost 10% of the population also claim incapacity benefit for what are perceived to be, in the main, preventable illnesses. Our case studies have focused on three PBC groups in NW SHA: Stockport PBC, Ashton, Leigh and Wigan PBC and Lancaster PBC. We interviewed members of these groups to explore different approaches to implementation of PBC and associated benefits and drawbacks.

These investigations were driven by the following questions:

1. What are the drivers that cause practices to engage and collaborate in PBC groups?
2. How do PBC participants collaborate and create structures of governance that transcend their own individual interests?
3. What are the skills and competencies they need and what support do they receive?
4. How are skills, competencies and actual practices of PBC, their success and failure related to existing infrastructures? How could these support PBC better?
5. How do participants create, share and combine knowledge of the efficacy and efficiency of existing services. How/Do they 'design' new ones? How could they be supported in their activities?

We sought answers to the first four questions by looking at structures of management and governance, and the way in which agreements with the respective Primary Care Trust were reached. The fifth question requires a deeper investigation into actual design practices and decision-making processes; this research is ongoing, focusing on a single case study with the Lancaster PBC group. This study touches more directly on the question of how and if clinicians work as service designers and how service design methods could support their work. Below we report on initial results for the first four questions, then introduce some preliminary discussion on the fifth.

General drivers for engagement in PBC

Clinicians have been attracted to engage into PBC groups mainly via three incentives and promises: financial support, professional development and wider control over healthcare service provision.

On a general level financial incentives provided to encourage GPs to sign up for the programme include a Directed Enhanced Service (DES) payment of 95 pence per patient to cover staff time, and the ability to retain 70% of any efficiency gains made (in prescription and referral charges, for example) to reinvest in further service improvement agreed with the PCT. Local PCTs may also supplement the DES with an LES (Locally Enhanced Services) payment increasing the financial value of involvement in PBC to the practices.

Indicative budgets for all PBC consortia have been agreed based on historic spend but are also due, (by 2009), to be based on 'fair shares', allocated according to specific health needs of the local population, giving those practices in areas of higher deprivation (with associated greater health needs) access to improved financial resources.

On the professional level, practical implementation of PBC innovations are also expected to provide facilities and expertise so that more surgery, testing and diagnostics will be performed in primary care settings, under the control of local clinicians. A Department of Health initiative is also promoting the use of GPs with Special Interests (GPwSI) who may take on new roles that have usually been the exclusive preserve of hospital consultants - particularly in the area of chronic long-term illness, although this is currently facing resistance from the hospital consultants

PBC groups have a lever for recognition of their role in recent Department of Health guidance which indicates that if PCTs do not support PBC and deliver on expectations, they will not achieve level 2 of World Class Commissioning, (a key government approval process giving increased autonomy to PCTs), and that both PCTs and SHAs will be held to account for effective delivery of successful PBC.

In considering different approaches to PBC, each of the three case studies below represents a particular model of implementation of PBC, with different levels of integration and support among GPs and within the PCT. They go from large overarching organisations with a high level of PCT involvement and support to loose agreements and smaller self-directed groups of clinicians.

Case Study 1 Stockport

Stockport is often presented as a 'best practice' example of how early uptake of PBC has led to innovation in both commissioning and providing new services. The Stockport PBC group has been driven by two visionary people, Dr. Ranjit Gill, chair of the PBC board, and Alison Tonge, the lead director for PBC and deputy chief executive/director of finance of

Stockport PCT, who together encouraged all of the 53 GP practices in Stockport to form one large commissioning group, giving greater influence and reducing the governance structures which might have proliferated with smaller PBC groups. Engagement exercises were facilitated by the PCT, which adopted a 'top down' approach to PBC implementation. Once formed, the PBC group elected to become an Industrial Provident Society, managing the whole PBC framework, and Stockport Managed Care (SMC), a charitable company, was formed in April 2007 with up to 45 staff from the PCT being seconded to SMC as business support. As such SMC have direct responsibility for almost all of the commissioning of health services within the PCT, managing a budget of £299 million for GPs with a patient base of 295,000 annually. Members of the society have developed a wide range of incentives and support structures for GP practices in the group, such as enhanced pension schemes, risk management and insurance, and even IT contracts. Membership of the Society is based on proportional representation, with larger GP practices having more representatives. Stockport Health Enterprise is a GP owned social enterprise subsidiary company of SMC, acting as the provider arm, managing the provision of estates. They are a national demonstrator site for the government Community Hospital initiative and will act as project managers for a new purpose built diagnostic and treatment centre in the area. Dr. Ranjit Gill clearly believes that PBC has improved patient care in the area, stating that, "[PBC is about] making health and social care for patients safer, faster, and more accessible, whilst making it more evidence based and cost effective for PCTs […] In the last 18 months, as a result of PBC, we've moved ECG (Electro-CardioGraph) recording, spirometry and ambulatory BP (Blood Pressure) monitoring over 24 hours into practices and we have redesigned the audiology service to shorten waiting times from two years to two weeks."

Case Study 2 Ashton Leigh and Wigan

As of July 2009, Ashton, Leigh and Wigan (ALW) PCT has six PBC groups with a patient list of around 50-65,000 for each group. The consortia self-formed around historical relationships and geographical boundaries. Activity of the PBC groups had been limited to some very small scale, local service changes with limited impact. Recently the ALW PCT have agreed to second some of their business management staff to particular PBC groups and now each group has a defined commissioning manager, commissioning assistant director support, public health support, finance, data and method management support. These are fully funded by the PCT as part of their support package for PBC. PBC groups have also now been provided with the services of an external consultant (Tribal Health Consulting) procured through the DoH Framework for External Support for Commissioners (FESC) programme, and this has been a catalyst for revitalising the PBC process. Each of the PBC groups has now been given a mandate to focus on one of the areas identified as priorities in the PCT local plan and six multi-disciplinary, multi-sectoral clinical service redesign panels draw members from primary and secondary care, local authority, community care, voluntary organisations and specific related patient organisations (such as Diabetes support groups) to examine patient care pathways and models of care. Only one of these pathways has so far produced a business case for service redesign, which will shortly be considered by the PCT, but other groups are following close behind.

Case Study 3 Lancaster

In North Lancashire, a 'hands off' approach has been taken to PBC where the PCT has left it to the GPs to organise themselves, and three PBC groups have formed around geographical boundaries. The Lancaster PBC which involves 13 GP practices and covers

Lancaster, Morecambe, Carnforth and Garstang is the one which the Design in Practice team will be working with. The Lancaster PBC operates a system where each practice is given one seat on the consortium board, but this is not allocated proportionally so, for example, Coastal Medical Group, who have a patient population of 32,000 have only one seat, the same as some small single-handed practices with populations of less than 5,000. This necessitates diplomatic negotiation between practice representatives to identify priority areas, common to the group, to focus their efforts for service improvement. The Lancaster PBC group have appointed their own business manager who is employed by the consortium, and have further (limited) data and business support provided by the PCT. The group came together with a philosophy of 'trying to expand the skills and capacity of every GP practice' so that they 'send less out of the practice, and send less into hospital care'. Proposals for service redesign in the PBC group have been led by what GPs in the consortium view as priorities - such as services which cost the practices the most money, (currently related to unscheduled hospital admissions), and specific interests of certain GPs, such as Chronic Obstructive Pulmonary Disease.

Skills, Competencies and support to facilitate innovation in PBC

As a mean of supporting GPs in producing business plans and commissioning new services, local Primary Care Trusts are expected to provide business support, including the provision of benchmarked data (which will allow each practice to compare referrals, prescribing and other patient related costs with other practices in the area and national figures), management support and skills training where necessary. The Department of Health have also provided an approved list of external consultant/ development partners with experience in PBC implementation through their 'Framework for the procurement of External Support for Commissioners' (FESC). These partners can be employed through the business budget for PBC to provide skills training and business support.

While in Stockport and Ashton, Leigh and Wigan PCTs the structure of PBC governance included training and business support, the PBC groups in North Lancashire have used their management budgets to employ their own dedicated business managers, who are provided with administrative support by the PCT. Data and financial support are provided by PCT employees, but this is hampered by the fact that these employees are not dedicated to PBC and struggle to find the time to provide adequate support to PBC. North Lancashire have also been slow to provide data on hospital admissions and referrals for the PBC groups (often because the hospital trusts have not provided adequate or coherent data to them). With limited internal business support, no current external development support, and the majority of control over commissioning and budgets remaining firmly in the hands of the PCT, the GPs in the group cannot really be said to be 'empowered' to commission new services.

Andy Maddox, a member of the Lancaster PBC group says: "we put business cases together. But that again is a skill on its own, I mean, as a GP I was never taught to write business cases. … it is actually quite a skill and obviously we have managers who are quite skilled but, again, this is new to them ... knowing you have to get in things like public health data you have to look at."

Two external influences contributing to innovation in healthcare service redesign may be said, therefore, to be roughly described in terms of Evidence-based Medicine and Experience-based Design. The provision of healthcare data and informatics, and process mapping, are important contributions of evidence-based medicine, which can be used to inform strategic development plans for healthcare services at national level, leading to large-

scale redesign of services to suit the majority or 'average' patient. However, it is recognised that it is the atypical patient and minority of Very High Intensity Users (VHIU) who cost the health services most money. Understanding the specific needs of particular patient populations and engaging them in service redesign is the province of Experienced-based design and the area in which design companies are most frequently involved. It often falls to Practice Managers to assimilate, interpret and prioritise the profusion of data, legislation updates, government guidance and examples of best practice which are sent in a continuous stream to practices each week. Finding the time and means in which to translate these in the best interests of the patient with regard to continuity of care, balancing and applying these in line with the daily clinical experience and expertise of patient needs locally, is a major challenge for most practices. There does seem to be a distinct lack of training at practice level which will give the clinicians and frontline staff the skills and tools to manage this challenge in a creative and innovative way.

Clinicians as Service Designers?

The case studies and the investigation into NHS reform and PBC have provided a partial representation of the current conditions within which clinicians operate and participate in the re-design of public services. As the research is still at an early stage, our answers are still partial, but they will become clearer as the investigation progresses.

The main question of the paper was if clinicians are or could work as professional designers and how this fits within the general transformations NHS is going through, PBC included. We acknowledge that the practice of designing is not exclusive to professional designers and that there are tacit practices of designing – that we call 'design in practice' (see silent design concept by Gorb and Dumas, 1987)– carried out by people that don't consider themselves as designers and that use different 'mind sets' and 'thinking modes' to approaching the development or improvement of health solutions.

Within healthcare governance these practices are now in a process of being formalised, bringing clinicians formally into commissioning roles. This provokes a reconsideration of the capacity of existing processes and structures for innovation, the adaptability and applicability of existing knowledge in new forms of decision making and the evolution of existing competencies to accommodate increasingly complex demands. With these challenges, is it possible that clinician's roles can be reformulated and transformed so that they recognise their function as that of designers developing new creations?

We would say that

1. Most clinicians already participate in service redesign at practice level, adapting their services in line with patient and government demands. What is changing is the levels of agreements/negotiation and scale of interventions that are dealt in PBC groups (bringing more clinicians together) and the manner in which this role is now more formalised. This process, in some cases, seems to bring closer alignment between PBC and PCT activities and skills,, generating an intermediate group of discussion between clinicians and PCTs, or, on another level, it may bring more managerial and design skills to the practice level, improving existing innovation processes; in either case the aim is to deal with local issues in a more informed, integrated and, at the same time, visionary way.

2. Clinicians seem to transfer only part of their familiar 'evidence based medicine' approach from a micro to a macro level in the consideration of healthcare services. Clinicians design clinical paths built on statistical and historical data provided by the PCT as well as best-

practice advice from central NHS agencies, often based on the pressing need to reduce costs and augment effectiveness. This approach doesn't necessarily include consideration of more qualitative approaches that look at individual patient experiences. Services, in this respect, are described as processes/operations and less as experiences.

3. Clinicians participating in PBC discussions may recognise the significance of their roles in wider change interventions, but these processes seem to be detached from daily discussions and negotiations about service improvements and re-design at practice level where daily issues of patient-staff interactions and service provision are dealt with. GPs, nurses, district matrons, etc. don't necessarily see themselves as contributing to design processes and don't recognise, accept, or have the time to consider, their involvement in broader issues of patient engagement or wider issues such as public health management. In this respect it is a matter of perspective and perception of roles, power, control and visibility.

In this process of formalisation of the role of clinicians in the commissioning and envisioning of new services we therefore advocate, on one side, the importance of making the existing 'design' processes at practice and PBC levels more explicit, visible and shared and, on the other side, creating a synergy between more 'evidence based' approaches with 'experience based' ones and also leveraging clinicians' tacit knowledge about their patients and territories. In doing so we acknowledge the potential role of service design skills and tools such as storytelling, scenarios and outside in and visionary approach as described in the following section.

The role of Service Design

What emerges from the description is the level of pressure, complexity and amount of interlinked problems clinicians need to deal with and how many stakeholders are directly or indirectly involved in the decision making process. Clinicians face the difficulty in negotiating priorities among several issues, and PCT structures demand business cases which evaluate in advance the impact of the service redesign proposals. Given this level of uncertainty and complexity clinicians look for evidence based solutions and datasets that can support their decisions as well as managerial and financial skills to create sustainable models. We have seen how PCTs have provided, or will provide, this support through training, consultancy and by introducing new professional roles into PBC.

What is not mentioned, as part of these support packages, are skills and methods related to user involvement, to make tacit knowledge explicit and usable during designing processes as well as related to the capacity to imagine and visualise radically new solutions. Tom Pickering, Business Manager of Lancaster PBC, recognised how the richness of knowledge doctors have about their clients ('1 millions of visits every year') and local community often remains implicit or only manifested as a general concern; he suggested that this makes it difficult then to evaluate if the concern is coming from a real need of users or from a personal interest of GPs (or a mix of both). The richness of their experience doesn't remain unused, but it is *ill-captured, not shared or exchanged,* reducing the power and influence they could bring into discussion tables as well as in the shaping of common visions.

The power of storytelling has been proved (Erickson, 1996; Bate and Robert, 2007) to be a relevant resource for design, to generate ideas and improvements and to challenge fundamental assumptions. Our questions are therefore: how can clinicians tacit knowledge be accessed during day-to-day activity and brought meaningfully into PBC meetings? How can it be used in a complementary way with more quantitative data? And how it can be

integrated in a systematic approach to generate ideas, set up priorities or generate business models?

PCTs are now required to make arrangements to involve users in planning, developing and delivering health services (DH, 2008). PBC groups, however, are not under any obligation, but still it is considered as 'a powerful tool for redesigning services, for providing innovative care and for making the best use of our resources. Most importantly, […] will help to deliver an NHS more responsive to patient's needs' (Hutton 2005). All PBC groups we interviewed are producing innovations at different levels, but it is not clear to us still how these ideas are generated and what are the sources of information they use. Both Stockport and Wigan seem to have developed ways to engage local communities and third parties to their commissioning activities as it has been integrated into their governance model. Lancaster PBC misses a clear plan for user involvement that perhaps reflects their less structured governance model. We argue that this is not necessarily a limitation as Lancaster PBC seems to have a strong commitment to the community and a belief in a bottom-up approach that manifests in its looser connection with PCT. We therefore argue that, given the richness of links with the community and of the knowledge of clinicians and community servers (i.e. district nurses and community matrons), it could be valuable to explore how clinicians could better make use of this knowledge in commissioning activities. The applicability and relevance of tool kits for 'creative thinking' (developed by NHSi 2007, Thinking Differently) and methodologies for EBD might be explored with PBC groups to investigate how these may be adapted in practice.

At the same time the case studies have shown how time needed to reach agreements among different stakeholders is often under estimated. This is amplified when the role and position of the PCT is not clear, or when contrasting interests reduce willingness to collaborate. A good driver for convergence is again the generation of a narrative, a vision or, in design terms, the building of a scenario (Carroll, 2000). Scenarios and storytelling are often interconnected methodologies that have the powerful potential to facilitate convergence on distant futures and in complex projects if employed in a participatory approach (Jegou, forthcoming; Raijmakers, forthcoming). The NHS North West has been applying scenario building to provide directions and inspirations to their Local Authorities (NHS North West, 2008); this process lasted one year based on 107 interviews and five scenarios building workshops, focusing on future healthcare landscapes. The same approach could be used at a smaller scale to support convergence and direction.

Considering the call for systematic approaches to innovation, our last question is about the degree to which the commissioning process is based on incremental changes arising from emerging concerns, as opposed to a process driven by a wider strategy. Again Stockport and Ashton PBC groups (as much as we could see) seem to have developed (or have been developing) a structured approach to innovation. Lancaster PBC has developed a common vision for 'a continuous expansion of capacity, personnel and skills of the Primary Care Health Team to manage as much care as possible within that team' (Lancaster PBC Business Plan, 2009/2010), but apparently a less structured approach to innovation. Both have strengths and weaknesses. While the unstructured approach can be viewed as a strength, as it can provide the space to work more closely with the local community in a more flexible way, it still requires coordination, methods and techniques to facilitate that.

Service Design consultants have been said to "view the service as a fluid arrangement of human and non-human artefacts, rather than a fixed intangible entity" by elaborating new 'value propositions' that unsettle existing configurations and generate new potentials for businesses (Kimbell, 2009). Service Designers have their own sets of methods that they constantly adapt to the situation and they have an outsider perspective. We ask how much

people within the system, can maintain that openness of imagination, without falling into existing situations or battling against conflicts of interests. And how much providing tools and a more structured approach to innovation can really increase the capacity to look at things in different ways. Service Design studios such as Engine or IDEO are famous for the development of interactive games that support organisations to reflect on their practice and think in different ways. This link between insider and outsider perspectives and their possible interconnection could be explored as well.

What next?

This paper has presented some first insights into PBC framework as it has been implemented in North West of UK. We started posing and answering key questions about the way PBC has been implemented to commission and co-design new services at a local level, showing the diversity of models of governance, support and collaboration.

The development of an effective mode of collaboration between PCT and PBC groups and among different stakeholders within the PBC groups themselves that could balance issues of control, resources and skills is still a big challenge. It seems that highly structured and PCT driven solutions are more effective, but probably weaken local control and real participation by clinicians.

A recent report by the King's Fund (2009) illustrates ongoing problems with practical application of PBC at local level where business cases are taking around 25 weeks to gain approval from the PCT (when guidelines state 8 weeks), then a further 25 weeks to actually become practice. Fifty two percent of PBC clinicians nationally said that they did not feel that their PCTs are making a real effort to engage them at decision-making level.

At the same time clinicians, because of limited managerial skills, resources and time, ask for support and for a clear vision from PCT to be able to deliver what they are asked to. In North Lancashire PCT, Jim Gardner, Medical Director of North Lancashire PCT, admits that, 'GPs have been disappointed that PCTs have often not seemed as willing to help and sort it out as they can ... it's about practicalities, about all the other things that are going on in the system. All the targets in fact, that as a health economy we have to achieve ... and they get in the way of some of this other redesign stuff that colleagues would like to do.'

This difficulty of balancing roles and contributions is mirrored by the low percentage of practices that think PBC has improved patient care; in quarterly results published by DoH the percentage of practices who think that PCB has not improved patient care sits at around 31% consistently, only around 16% believe patient care has improved.

From the Service Design point of view, we believe clinicians could benefit from using service design tools and service design can benefit by learning how to take the synergy between evidence based medicine and experience based design more seriously. Clinicians would benefit from expressing and using their knowledge about their communities in more designerly ways. Clinicians and PCTs consider statistical data as the main source for motivating and imagining services, missing out an extremely rich source of knowledge that comes from daily work of doctors and nurses. Modes to engage patients and to record and communicate their understanding and experiences should be integrated into commissioning activities and training packages to compliment organisational development approaches. This would help to improve GP's role in the negotiations processes and result in better quality briefs for new services.

The Design in Practice team are involved at two levels within North Lancashire PCT, working with the Lancaster PBC group and, specifically, with Coastal Medical Group in Morecambe. The focus of the current research will be the exploration of modes of connection between practitioners and patients (particularly those from typically disenfranchised groups) as well as how to acknowledge, communicate and bring into commissioning groups existing knowledge and daily experience of clinicians and community carers such as district nurses and community matrons. We will explore how these insights into patients needs might be integrated into practice development at GP level, and into commissioning of services at PBC level as well as how they might generate radical visions for the future of health services.

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